No. 87-5096

IN THE

Supreme Court of the United States

OCTOBER TERM, 1987

QUINCY WEST,

Petitioner,

vs.

SAMUEL ATKINS,

Respondent.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

AMICUS CURIAE BRIEF OF THE AMERICAN CIVIL LIBERTIES UNION FOUNDATION, THE NATIONAL PRISON PROJECT OF THE ACLU FOUNDATION, AND THE NORTH CAROLINA CIVIL LIBERTIES UNION LEGAL FOUNDATION IN SUPPORT OF PETITIONER

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QUESTIONS PRESENTED

1. Did a physician who was under contract to provide orthopedic services to inmates at a state prison hospital act under color of state law for purposes of §1983 in his treatment of a North Carolina state prison inmate?
2. Do prison physicians--whether permanent members of a state prison medical staff, or under contract with the state prison--act under color of state law for purposes of §1983 liability in their treatment of state prison inmates?

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INTEREST OF AMICI[1]

The American Civil Liberties Union Foundation (ACLUF) is a nationwide, non-partisan organization of over 250,000 members. The ACLUF is dedicated to preserving and protecting the Bill of Rights. The North Carolina Civil Liberties Union Legal Foundation is one of the ACLUF's state affiliates. The ACLUF established the National Prison Project in 1972 to protect and promote the constitutional and civil rights of inmates. The National Prison Project is the only public interest prison litigation project in the country with a national docket and the Project has a particular interest in prison health care issues.

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[1] The parties have consented to the filing of this brief, as indicated by their letters of consent filed with the Clerk of the Court.

STATEMENT OF THE CASE

On November 23, 1984, the petitioner, a prisoner in the North Carolina prison system, filed a pro se complaint alleging that two prison administrators and Dr. Atkins, a physician under contract to the prison system, had been deliberately indifferent to his serious medical needs regarding a torn tendon.[2]

The response filed by the Attorney General's Office on behalf of Dr. Atkins indicated that Dr. Atkins received over $50,000 per year to provide two weekly orthopedic clinics to prisoners at the

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[2] Among petitioner's allegations in his complaint was that another physician under contract to the North Carolina system had ordered petitioner transferred to another prison for medical treatment. (R.5) Such transfers are provided for in the North Carolina Department of Correction Health Care Procedures §203.3(B). Petitioner also alleged in his complaint that, among numerous other attempts to procure medical treatment, he had filed a grievance through the institutional grievance system about Dr. Atkins, and that the prison's response to the grievance had been that petitioner was scheduled to see Dr. Atkins. R.10.

Central Prison Hospital. Although the affidavits filed in connection with the Attorney General's response alleged generally that contract physicians had no custodial or supervisory duties in relation to prisoners,[3] the affidavits do not specifically deny the allegations of the complaint.[4] In addition, the affidavits indicate that the medical service providers are under the administrative authority of the warden of the unit, so that the warden can order a contract physician to examine a specific prisoner. R.28. The contract physicians are also subject to the regulations and orders outlined in the Department's Health Care Procedures Manual, which orders are also approved by the unit

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[3] R.23, R.29.

[4] For example, the affidavits do not deny the petitioner's allegations cited in n.2, supra.

physician. Id.[5]

The trial court granted summary judgment that Dr. Atkins' alleged conduct did not constitute state action. A panel of the Fourth Circuit reversed and remanded. West v. Atkins, 799 F.2d 923 (4th Cir. 1986).

Subsequently, the Fourth Circuit Court of Appeals en banc reversed the panel and reinstated the summary judgment against the petitioner. West v. Atkins, 815 F.2d 993 (4th Cir. 1987).[6] While the precise holding of the Court of Appeals in its en banc decision is somewhat unclear, the holding appears to be that a prison physician does not act under color of state law

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[5] The Manual prescribes, for example, the precise procedures that a physician must follow when giving an intake physical and placing a prisoner in a health grade for purposes of work assignments. (§202.2).

[6] Whether the complaint states a claim under Estelle v. Gamble, 429 U.S. 97 (1976) has not been decided by any lower court and is not before this Court.

except when the physician performs custodial and supervisory, rather than strictly medical, duties. Apparently the Fourth Circuit would not have found state action to be present even if Dr. Atkins had been a full-time state employee. Id. at 995.

It is possible that the holding is substantially narrower, that the acts of a contract physician do not constitute state action. If this is the holding, then the case restates the rule the Fourth Circuit established in Calvert v. Sharp, 748 F.2d 861 (4th Cir. 1984), cert. denied, 471 U.S. 1132 (1985).

This Court granted a writ of certiorari on October 19, 1987.

SUMMARY OF ARGUMENT

The decision of the Court of Appeals may stand for two different rules, one of which is considerably broader than the other. Apparently the decision of the Court of Appeals stands for the principle

that the acts of a physician in the course of undertaking the medical treatment of a prisoner do not constitute state action. It is possible that the decision may stand for the narrower proposition that the acts of a physician under contract to provide medical care do not constitute state action.

Prison medical care has a tradition of deliberately indifferent care for three interrelated reasons: prisoners are an isolated and disliked minority; prisons are closed institutions; and prisoners have no choice in the medical care provided them. These factors significantly increase the possibilities for the misuse of power, requiring a finding that prison medical care constitutes state action.

Because prisons have a constitutional duty to provide medical care and because prisoners have no choice in medical care, prison medical care is an exclusively

public function, so that state action is present. Similarly, the close relationship between the State and physicians delivering medical care satisfies the "nexus" test for state action. Indeed, the symbiotic relationship among the State, the physician and the prisoner makes this case legally indistinguishable from Burton v. Wilmington Parking Authority, 365 U.S. 715 (1961).

The central error in the decision of the Court of Appeals comes from its misapplication of Polk County v. Dodson, 454 U.S. 312 (1981). The Court of Appeals wrongly focused on the relationship between the public defender and her client in Polk County, when the Court of Appeals should have analyzed the relationship between the public defender and the State. On this test, which was the basis for this Court's analysis in Polk County, prison physicians lack the uniquely adversarial relationship with the State that justified the refusal

to find state action in Polk County.

Finally, affirmance of the decision of the Court of Appeals, on either the broad or narrow grounds asserted by the Fourth Circuit, will have disastrous effects in reversing recent improvements in prison health care. If this Court should affirm on the broad ground, such a decision would remove most challenges to prison medical care, including injunctive actions, from the reach of the Constitution. Even if this Court were to affirm the Court of Appeals on the narrow ground of the respondent's status as a contract physician, such a decision would have the undesirable result of providing prison administrators with a subterfuge for avoiding federal court review.

ARGUMENT

I. MEDICAL CARE IN PRISONS HAS TRADITIONALLY BEEN DISTINCTLY SEPARATE FROM AND INFERIOR TO COMMUNITY HEALTH CARE

The apparent holding of the Court of Appeals that the actions of a prison physician[7] performing medical duties do not constitute state action, if adopted by this Court, would radically alter the current understanding of the state action doctrine and in substance overrule this Court's decision in Estelle v. Gamble, 429 U.S. 97 (1976), that deliberate indifference to the serious medical needs of prisoners violates the Eighth Amendment.

The consequences to prison health care of a decision insulating such care from

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[7] While we speak throughout this brief of physicians, other prison medical practitioners, including nurses and physicians assistants, may well be affected by the decision in this case. The decision of the Court of Appeals does not clearly address whether the acts of such auxilliary health care providers constitute state action.

federal court review under the Estelle v. Gamble standard are extraordinarily serious, because federal court review has played a critical role in protecting prisoners from grossly inadequate and sometimes horrifying failures to provide basic medical care.

In Appendix I, we provide excerpts from just a few of the published cases in which federal courts found themselves required to enter a comprehensive injunctive order because of systemic failures to provide adequate medical care. These cases are but a sample of the cases that have found prison medical systems to be deliberately indifferent to the serious medical needs of prisoners.[8] The cases

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[8] See also Hoptowit v. Ray, 682 F.2d 1237 (9th Cir. 1982); Inmates of Allegheny County Jail v. Pierce, 612 F.2d 754 (3rd Cir. 1979), on remand, 487 F.Supp. 638 (W.D.Penn. 1980); Todaro v. Ward, 431 F.Supp. 1129 (S.D.N.Y. 1977), aff'd, 565 F.2d 48 (2nd Cir. 1977); Inmates of Occoquan v. Barry, 650 F.Supp. 619 (D.D.C. 1986); Balla v. Idaho State Board of Corrections, 595 F.Supp. 1558 (D.Id. 1984); Martino v. Carey, 563 F.Supp. 984 (D.Or. 1983); Capps v. Atiyeh, 559 F.Supp. 894 (D.Or. 1982); Burks v. Teasdale, 492 F.Supp. 650 (W.D.Mo. 1980); and Palmigiano v. Garrahy, 443 F.Supp. 956 (D.R.I. 1977), cert. denied, 449 U.S. 839 (1980).

demonstrate patterns of failures[9] to

[9] The once widespread practice of using untrained prisoners as "nurses," referred to in some of the excerpts in Appendix I, is one such pattern. See also Cody v. Hillard, 599 F.Supp. 1025 (D.S.D. 1984), rev'd on other grounds, 830 F.2d 912 (8th Cir. 1987) (en banc); Grubbs v. Bradley, 552 F.Supp. 1052, 1129 (M.D.Tenn. 1982); and Nicholson v. Choctaw County, Alabama, 498 F.Supp. 295 (S.D.Ala. 1980). Interestingly, North Carolina is among the states that still allows the use of prisoners to provide health care services. §714.2 of the Department's Health Care Procedures Manual allows the use of prisoners as x-ray technicians, operating room technicians, nurses' aides and physical therapy assistants.

Another systemic source of deliberate indifference is the practice in some states of using physicians who are not allowed to treat ordinary citizens to provide medical services in prisons. Four states, Florida, Colorado, Kansas, and Vermont currently grant limited or special institutional licenses to physicians allowing them to practice in penal institutions. Additional states have discontinued the practice of allowing unlicensed physicians to work in prisons, including Alabama, North Dakota and Oklahoma. See Federation of State Medical Boards of the United States, The

examine and diagnose; failures to provide universally recognized treatment; failures to provide basic nursing care; delegations of medical duties to untrained persons, including prisoner "nurses"; failures to have available necessary medical equipment; and pure neglect.

As this Court noted in Rhodes v. Chapman, 452 U.S. 337 at 352 (1981), "[c]ourts certainly have a responsibility to scrutinize claims of cruel and unusual confinement, and conditions in a number of prisons, especially older ones, have justly been described as 'deplorable' and 'sordid.'"[10] Precisely because federal

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Exchange (1987), (medical licensing survey). See also Vt.Stat.Ann.tit.3, §261 (1987) and Colo.Rev.Stat. §17-1-101 (1986).

[10] In addition to citing Bell v. Wolfish, 441 U.S. 520 (1979), the Court in Rhodes, at this point in its opinion cited in a footnote cases in which federal courts had granted relief on a number of conditions of confinement, including, in all cases, the denial of adequate medical care. 452 U.S. 352, n.17.

courts have discharged their duties, prison medical care has made enormous strides in the last twenty years. If prison physicians who perform medical functions with deliberate indifference to serious medical needs are not within the reach of the Constitution, then the possibility of federal court intervention in a State's prison health care system will all but disappear. Removal of the possibility of federal intervention could have disastrous consequences for these recent improvements in prison medical care.

Some of the possible consequences of the removal of constitutional review of prison medical care can be seen by examining prison medical care in Maryland. Beginning in 1981, Maryland moved to a contract system in order to provide comprehensive health care for prisoners confined to its penal facilities. According to a 1986 Study commissioned by the Maryland

Legislature, the State by contracting with a private provider intended to shift its responsibilities for the delivery of health services[11] and apparently also sought to avoid federal court intervention and liability for injuries suffered as the result of inadequate treatment and care.[12]

The Study found that the State did not monitor how the private providers carried out its obligations under the contract. According to the Study "...there was

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11 Virtually all the medical care provided to Maryland prisoners is provided through contract services rather than directly by state employees. NKC Management, Evaluation of the State of Maryland's Medical Services Program for Inmates, November, 1986, pp. 3-5, 19, 32.

12 While "[i]t was impossible for [the Study] to determine the motivation for this transition [to a private contractor].... there was certainly the implied assumption that by contracting, DOC put distance between itself and the ever present liability for adequate health care." Study at 19. Cf. Burton v. Wilmington Parking Authority, 365 U.S. 715 at 725 (1961): "But no state may effectively abdicate its responsibilities by either ignoring them or by merely failing to discharge them whatever the motive may be."

certainly the implication that since the delivery of health care was 'turned over' to the contractor, DOC was relieving itself of at least this area of responsibility. This attitude was manifest by gross management inattention."[13]

The Study found that even under the contract Maryland maintained a "non-system" that "historically.... harbor[s] a great deal of undiagnosed and untreated disease."[14] To underscore this conclusion the Study was severely critical of the health care program's performance during a 1983 syphilis epidemic at the House of Correction and "difficulties associated with a tuberculosis outbreak" in 1984.[15]

The apparent decision of the State of Maryland to attempt to avoid constitutional

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13 Id. at 19. See also 97, 143, 180 and 193-196.

14 Id. at 99.

15 Id. at 111.

constraints proved successful when the Fourth Circuit decided Calvert v. Sharp, supra, holding that actions of the Maryland contract physicians did not constitute state action. Accordingly, under current Fourth Circuit doctrine, Maryland prisoners have been deprived of any obvious possibility of constitutional protection from systemically deficient medical care.

The sequence of events in Maryland illustrates the dangers of affirming the Court of Appeals on either broad or narrow grounds. If the Court of Appeals were to be affirmed on the broad ground that all medical care offered prisoners by physicians is beyond the reach of the Constitution, then prison health care might generally revert to its former state. If an affirmance were limited to contract care physicians, other states might join Maryland in choosing contract health care simply to avoid constitutional requirements.

II. THE STATE ACTION DOCTRINE MUST BE CONSTRUED IN LIGHT OF THE UNIQUE RELATIONSHIP BETWEEN PRISONERS AND THE STATE

The tradition of severely deficient prison health care must be considered in determining the reach of the state action doctrine because, for the reasons set forth in this section, this tradition results from the unique legal relationship between the State and prisoners. This unique relationship removes the ordinary checks against the misuse of power possessed by virtue of state law. It is, of course, this misuse of power made possible because the wrongdoer is clothed with the authority of state law that justifies a finding of state action. Cf. United States v. Classic, 313 U.S. 299, 326 (1941).

There are three primary reasons for the problems in prison health care discussed in the previous section of this brief: (1) the political process is

unlikely by itself to protect the interests of prisoners in basic health care; (2) the medical care provided prisoners is likely to be isolated from the medical care provided in the community; and (3) market controls on the quality of services do not operate because prisoners uniquely have no option to reject the medical care profferred by the state.

First, prisoners are the paradigmatic example of a "discrete and insular" minority that is hampered by the kind of public prejudice that "tends seriously to curtail the operation of those political processes ordinarily to be relied upon to protect minorities."[16] While the general prejudice against prisoners has understandable roots, no one suggests that the appropriate punishment for crime includes the denial of basic medical care.

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16 United States v. Carolene Products Co., 304 U.S. 144, 152, n.4 (1938).

Aside from the Eighth Amendment bar to such punishment, denial of basic medical care would operate irrationally as a punishment. Comparatively minor offenders could be the most heavily punished if they happened to have serious medical needs.

The second factor that should affect the reach of the state action doctrine in the context of prison medical care is the obvious fact that prisons are not, by their nature, open institutions. It is this fact that provides much of the justification for the application of the Eighth Amendment to prisons. Cf. Ingraham v. Wright, 430 U.S. 651, 669-670 (1977):

> The prisoner and the school child stand in wholly different circumstances, separated by the harsh facts of criminal conviction and incarceration. The prisoner's conviction entitles the State to classify him as a "criminal," and his incarceration deprives him of the freedom "to be with family and friends and to form the other enduring attachments of normal life".... Prison brutality, as the Court of Appeals observed in this case, is

> "part of the total punishment to which the individual is being subjected for his crime and, as such, is a proper subject for Eighth Amendment scrutiny."
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> * * *
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> The openness of the public school and its supervision by the community afford significant safeguards against the kinds of abuses from which the Eighth Amendment protects the prisoner.... As long as the schools are open to public scrutiny, there is no reason to believe that the common-law constraints will not effectivcly remedy and deter excesses such as those alleged in this case.

(Citations and footnotes omitted)

The closed nature of prison institutions is one of the major factors that has led to a class of medical care in prisons, distinctly different from, and inferior to, medical care provided to the general community.

The third important factor structurally affecting prison health care is the fact that prisoners almost universally have no choice regarding medical care. See

Appendix II, infra. The sole source of the medical care that a prisoner is eligible to receive is that care that the State chooses to provide. Cf. Preiser v. Rodriguez, 411 U.S. 475, 491-492 (1973):

> It is difficult to imagine an activity in which a State has a stronger interest, or one that is more intricately bound up with state laws, regulations and procedures, than the administration of its prisons. The relationship of state prisoners and the state officers who supervise their confinement is far more intimate than that of a State and a private citizen. For state prisoners, eating, sleeping, dressing, washing, working, and playing are all done under the watchful eye of the State, and so the possibilities for litigation under the Fourteenth Amendment are boundless. What for a private citizen would be a dispute with his landlord, with his employer, with his tailor, or with his banker becomes, for the prisoner, a dispute with the State.[17]

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[17] The Court in Preiser noted the unusual relationship of prisoners to the State in the context of applying an exhaustion requirement to challenges to the fact or duration of confinement under the habeas corpus statute. The Court specifically reaffirmed, however, that §1983 is "a proper

This Court has specifically recognized that the State has an obligation to provide medical care to prisoners:

> These elementary principles establish the government's obligation to provide medical care for those whom it is punishing by incarceration. An inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met.

Estelle v. Gamble, 429 U.S. at 103. See also City of Revere v. Massachusetts General Hospital, 463 U.S. 239, 244 (1983) (due process clause requires the responsible government agency to provide medical treatment to persons injured while being apprehended by the police) and Youngberg v. Romeo, 457 U.S. 307, 317 (1982).[18]

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remedy for a state prisoner who is making a constitutional challenge to the conditions of his prison life, but not to the fact or length of his custody." Id. at 499.

[18] The Court's pronouncements on this issue also reflect the common-law rule that the State must provide medical care for prisoners because incarceration makes it impossible for prisoners to secure their own care. Ironically, the case widely cited for

Although these three factors--prisoners' low status in society, the closed nature of prisons, and prisoners' abnormal degree of dependency upon the State for the most basic necessities of life--are logically distinct, their effects are harder to disentangle.

One consequence of the status of prisoners is that, if not an "iron curtain,"[19] between medical care in the community and prison medical care, there have certainly been important barriers between the two. These barriers make possible the misuse of power under the apparent authority of state law and have

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the common-law rule is a North Carolina case. Spicer v. Williamson, 191 N.C. 487, 490, 132 S.E. 291, 293 (1926), cited in Estelle v. Gamble, 429 U.S. at 104, n.9. Spicer was not a malpractice case; it involved a dispute among a doctor, a sheriff, and a county Board of Commissioners over responsibility for the cost of surgery for a jail inmate.

[19] Cf. Wolff v. McDonnell, 418 U.S. 539, 555-556 (1974).

resulted in prison medical care that has been both distinct from community health care and distinctly inferior.

III. PRISON MEDICAL CARE IS A PUBLIC FUNCTION

A. Prison Medical Care Involves a Constitutional and Common-Law Duty

Prison medical care is different from most other things that governments do. Prison medical care is a public function because it is an inescapable duty of the State to provide such care. See pp. 21-22, supra. It was precisely at this point that the Court of Appeals made a significant error. The Court of Appeals analyzed whether medical care, in general, was an exclusively public function, and understandably decided that it was not. West v. Atkins, 815 F.2d at 996, n.2.

Obviously, the correct analysis would have been to determine whether prison medical care, not medical care in general,

is an exclusively public function. Cf. Youngberg v. Romeo, 457 U.S. at 317:

> As a general matter, a State is under no constitutional obligation to provide substantive services for those within its borders. See Harris v. McRae, 448 U.S. 297, 318, 100 S.Ct. 2671, 2689, 65 L.Ed.2d 784 (1980) (publicly funded abortions); Maher v. Roe, 432 U.S. 464, 469, 97 S.Ct. 2376, 2380, 53 L.Ed.2d 484 (1977) (medical treatment). When a person is institutionalized and wholly dependent on the State it is conceded by petitioners that a duty to provide certain services and care does exist, although even then a State necessarily has considerable discretion in determining the nature and scope of its responsibilities.

(Citations omitted)[20]

When a private entity exercises powers that are traditionally and

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[20] Because medical care in general is not an exclusively public function, petitioner's position is consistent with the Court's decision in Blum v. Yaretsky, 457 U.S. 991, 1011 (1982) (medicaid recipients failed to establish that state action existed in nursing homes' decision to discharge or transfer medicaid patients; nursing homes do not perform an exclusively public function).

exclusively reserved to the State, state action exists.[21] Jackson v. Metropolitan Edison Company, 419 U.S. 345, 352 (1974). Where the State has a duty to perform the function, state delegation of the duty to an ostensibly private actor does not strip performance of the duty of its character as a public function. Cf. Jackson v. Metropolitan Edison Company at 352-353:

> If we were dealing with the exercise by Metropolitan of some power delegated to it by the State which is traditionally associated with sovereignty, such as eminent domain, our case would be quite a different one. But while the Pennsylvania statute imposes an obligation to furnish service on regulated utilities, it imposes no such obligation on the State. The Pennsylvania courts have rejected the contention that the furnishing of utility services is either a

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[21] In this brief, amici discuss only the state action doctrine. We do not discuss separately the test of whether the action occurred under color of state law because these doctrines lead to identical results. United States v. Price, 383 U.S. 787, 794, n.7 (1966); see also Lugar v. Edmondson Oil Co., Inc., 457 U.S. 922, 927-932 (1982).

> state function or a municipal duty.

(Citations omitted)

In contrast, the North Carolina courts have specifically held that the State does have a duty to provide medical care for prisoners. Spicer v. Williamson, 191 N.C. 487, 490, 132 S.E. 291, 293 (1926).

B. Prison Health Care Is Exclusively a Public Function

In Flagg Bros., Inc. v. Brooks, 436 U.S. 149, 159 (1978), this Court noted that the branches of the public function doctrine had in common the feature of exclusivity:

> Although the elections held by the Democratic Party and its affiliates were the only meaningful elections in Texas [so that state action was found in Terry v. Adams, 345 U.S. 461 (1953)], and the streets owned by the Gulf Shipbuilding Corp. were the only streets in Chickasaw, [so that state action was found in Marsh v. Alabama, 326 U.S. 501 (1966)], the proposed sale by Flagg Brothers under §7-210 is not the only means of resolving

> this purely private dispute. Respondent Brooks has never alleged that state law barred her from seeking a waiver of Flagg Brothers' right to sell her goods at the time she authorized their storage.

Flagg Bros., Inc., at 159-160.

In short, Flagg Bros., Inc. interpreted exclusivity to mean that the affected citizen had no choice. Under this definition, prison health care is an exclusively public function in this case, because by state law the only medical care the petitioner can receive is medical care provided by the State through Dr. Atkins.[22] Our survey of state statutes indicates that virtually all states deny prisoners the option to choose medical care of their own

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[22] The Chief of Health Services in North Carolina can approve applications by minimum security prisoners to obtain medical services outside the Department at the prisoner's own expense. Department of Correction Health Care Procedures Manual §710.2. Petitioner was not a minimum security prisoner.

choice.[23] See Appendix II.

In short, this case involves a duty on the part of the State, recognized under the United States Constitution, the decisional law of the State, and the affirmative command of state law, that prisoners have no choice but to accept the medical care the State chooses to provide.[24]

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[23] Contrary to the impression created in the Fourth Circuit's previous decision in Calvert v. Sharp, 748 F.2d 861 (4th Cir. 1984), cert. denied 471 U.S. 1132 (1985), prisoners in Maryland also have no choice about the provision of medical care. The Maryland statute relied upon by the Fourth Circuit in Calvert gives to the State the right to determine that prison facilities are inadequate, so that the prisoner may be treated elsewhere. It remains exclusively the State of Maryland's prerogative to determine who treats the prisoner and where. See Md. Code. Ann. Art. 27 §698 (1982).

[24] This case does not require the Court to address the reach of the state action doctrine with regard to the actions of a physician providing care in the community who occasionally treats a prisoner for serious medical needs. On the one hand, the prisoner's lack of choice would suggest that state action is present. On the other hand, care in the community generally differs from traditional prison health care because it takes place in an open environ-

IV. THE NEXUS BETWEEN THE STATE AND DR. ATKINS IS SO CLOSE THAT PETITIONER'S TREATMENT IS FAIRLY CHARGEABLE TO THE STATE

In Lugar v. Edmondson Oil Co., Inc., 457 U.S. 922 (1982), the Court set up a two-part test for determining whether conduct allegedly causing the deprivation of a federal right may be fairly attributed to the State:

> First, the deprivation must be caused by the exercise of some right or privilege created by the State or by a person for whom the State is responsible[25]... Second, the party charged with the deprivation must be a person who may fairly be said to be a state actor. This may be because he is a state official, because he has acted together with or has obtained significant aid from state officials, or because his conduct is otherwise chargeable to the State.

ment. For that reason, the possibilities for the misuse of power are reduced and a finding of state action is less necessary to protect core constitutional values.

[25] In this case, of course, the first test under Lugar is met because the State has exercised its right to imprison the petitioner and has further deprived the petitioner of any method apart from the State to provide for his medical needs.

Id. at 937

One of the specific tests established by the Court for the second component of the state action test is the "nexus" test. Lugar at 938-939, citing Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1975). As noted supra, in Jackson this Court first found that the utility did not perform a public function because the State was under no obligation to provide utility services. The Court then undertook a factual analysis of the various facets of the interaction between the State and the utility, and concluded that the State under the particular facts of the case was not tied closely enough to actions of the utility for the utility to be characterized as a state actor. Jackson at 358-359.

In this case, Dr. Atkins was provided over $50,000 per year to provide care on state premises for patients whom the State

was required to treat. On this record, the authority to order medical transfers was shared between the contract physicians and custody staff.[26] The State's direct control over the contract physicians included the warden's right to order the examination of specific prisoners and the physicians' responsibility to practice in accordance with the Department's Health Manual.[27] Accordingly, in this case the

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[26] The affidavits filed by respondents in the trial court did not specifically discuss the allegations of the complaints with respect to prisoner medical transfers. The affidavits deny in a conclusory fashion that Dr. Atkins has any custodial or supervisory services. The Health Care Procedures Manual of the Department of Correction sets forth the procedures for medical transfers to Central Prison Hospital. See §203.3(B). Since the case was decided on summary judgment, the allegation that contract physicians can order transfers should be taken as true for the purposes of deciding whether summary judgment was appropriate.

[27] See p.4, n.5, supra, setting forth some of the instances in which physicians must follow medical procedures prescribed by the Manual. In Jackson, the state utility commission simply approved a practice applicable to the utility, but did not overtly or covertly intend to encourage

close nexus between the State and Dr. Atkins requires a finding of state action.

The failure of the Court of Appeals to examine the close nexus between Dr. Atkins and the State led it to another fundamental error. A basic premise of the decision of the Court of Appeals is that there is a bright line between medical and custodial functions in the context of correctional medicine. No such bright line exists. As the Department of Correction Health Care Procedures Manual states:

> The provision of health care is a joint effort of correctional administrators and health care providers, and can be achieved only through mutual trust and cooperation.

§100.5

This record illustrates a few of the points at which such a line disappears. One such instance is, of course, peti-

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the practice. 419 U.S. 350, n.7. Here, the Department's Manual, issued on behalf of the State, applies to both contract physicians and state employees. R.28.

tioner's transfer to another prison for medical treatment. Another such point that petitioner notes in his complaint is his reference to having his medicine taken from him when he arrived at a new prison. "After plaintiff protested the nurse explained that it were (sic) a prison policy that such medication entering central (prison) be seized and that plaintiff would be scheduled to see the doctor so the medication could be re-prescribed by the unit Doctor." R.7. In addition, the complaint refers to petitioner's understanding that Dr. Atkins would prescribe something other than standard prison-issue shoes, although apparently Dr. Atkins never prescribed such shoes. R.8.

Other common examples of the blurring of the medical and custodial roles include performing x-rays or body cavity searches

for security reasons[28] and examining a prisoner to determine if there is a medical reason to exempt him or her from prison duties.[29]

The close nexus between the State and medical care providers requires this Court to reject the argument that a prison medical provider's duties can be divided into artificial categories of purely medical and purely custodial duties.

V. POLK COUNTY v. DODSON DOES NOT CONTROL THIS CASE

In both its broad and narrow

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28 See, e.g., U.S. v. Lilly, 576 F.2d 1240, 1243 (5th Cir. 1978). The Department of Correction Health Care Procedures Manual requires that medical personnel perform body cavity searches. See §704.2.

29 See, e.g., Finney v. Mabry, 534 F.Supp. 1026, 1033, n.1 (E.D.Ark. 1982). In his complaint, petitioner refers to being confined to his bed for a week by the unit physician. R.11. The Department of Correction Health Care Procedures Manual provides that physicians will place a prisoner in a particular health care classification. This classification determines eligibility for work assignments. See p.4, n.5, supra.

rulings,[30] the Court of Appeals erroneously applied Polk County v. Dodson, supra, to this case. In Polk County, this Court decided that a public defender does not act under color of state law when he or she represents an indigent defendant. Essentially, this Court gave three related reasons for its decision.

First, the Court noted that unlike the institutional physicians in Estelle v. Gamble, supra, and O'Connor v. Donaldson, 422 U.S. 563 (1975), the public defender owes a duty of undivided loyalty to the client. The physicians in O'Connor and Estelle, on the contrary, "assume an obligation to the mission that the State, through the institution, attempts to achieve." Polk County at 320.

Although the Court in Polk County also noted that the physicians sued in O'Connor and Estelle held supervisory positions, the

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30 See pp. 4-5, supra.

actions for which they were sued involved their medical functions. The particular actions that O'Connor and Estelle implicitly considered as state action were actions undertaken as treating physicians--precisely the actions of Dr. Atkins challenged by petitioner.

As noted above, the record in this case in fact shows a close relationship between the medical and custodial actions of a contract physician like Dr. Atkins. In contrast, this Court distinguished public defenders from the physicians in Estelle and O'Connor precisely because all of the public defenders' functions were adversarial to the State.

The second reason this Court gave in Polk County for not finding state action is that a public defender is not amenable to administrative direction in the same sense as other employees of the State. Polk County at 321. Both contract and direct

employee physicians in North Carolina, including Dr. Atkins, use a Manual promulgated by the State that specifies important treatment areas in which physicians are subject to administrative direction by the State.[31]

Finally, this Court in Polk County placed great reliance on the paradoxical nature of the duty of the State to provide legal counsel to indigent defenders. Although the State has such a duty, at the same time the State must provide legal counsel "free of state control." Id. at 322. This special adversarial relationship between public defender and the State

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31 The Court also noted that public defenders are "held to the same standards of competency and integrity as a private lawyer." Id. As noted at pp. 11-12, n.9, supra, prison doctors in several states are not necessarily held to the same licensure standards as physicians treating the general public. Moreover, the actions of lawyers are automatically subject to considerable scrutiny by the courts before which they practice. There is no comparable source of automatic review for the actions of physicians.

explicitly underlies the Polk County decision and distinguishes prison doctors from public defenders.

In addition to its misapplication of this Court's decision in Polk County, the decision of the Court of Appeals also ignored Youngberg v. Romeo, 457 U.S. 307, supra, in which this Court held that an institutionalized mentally retarded citizen had a protected liberty interest in reasonably safe conditions of confinement and freedom from unreasonable bodily restraints. Although the defendants in Youngberg were administrators and not physicians,[32] the standards for damages liability established by the Court obviously do not distinguish between physicians and other professionals. This Court held that liability for constitutional violations could be imposed on a professional only when the decision by the

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32 Id. at 310, n.3.

professional is such a substantial departure from accepted professional judgment, practices or standards that the responsible person did not base the challenged decision on such a judgment. Id. at 323. In the course of this holding, the Court specifically defined the term professional in a manner equally applicable to correctional administrators and physicians:

> By "professional" decision-maker, we mean a person competent, whether by education, training or experience, to make the particular decision at issue. Long-term treatment decisions should be made by persons with degrees in medicine or nursing, or with appropriate training in areas such as psychology, physical therapy, or the care and training of the retarded.

Id. at n.30.

Accordingly, the decision of the Court of Appeals, which on its face exempts all physicians except possibly those with obvious supervisory or custodial functions from the commands of the Constitution, is

directly inconsistent with this Court's standards for liability for damages under the Constitution as set forth in Youngberg.

VI. THE DECISION OF THE COURT OF APPEALS CANNOT BE RECONCILED WITH BURTON v. WILMINGTON PARKING AUTHORITY

Affirming the Fourth Circuit decision, even on the narrower ground focusing on the physician's status as an independent contractor, would require the overruling of Burton v. Wilmington Parking Authority, supra, a central case in the modern development of state action law.[33] Burton involved a parking authority owned and operated by the State that had as a lessee a private restaurant. The Court found that

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[33] Although this Court has on occasion distinguished Burton, it has never suggested that Burton is no longer good law. See, e.g., Rendell-Baker v. Kohn, 457 U.S. 830, 842-843 (1982). Indeed, the very factors that Rendell-Baker stressed as distinguishing that case from Burton (that the relevant functions took place on public property and that the State profited from the unconstitutional conduct), in this case argue for the application of Burton.

there was a symbiotic relationship among the Parking Authority, the restaurant and the particular state action challenged: the existence of the parking encouraged patrons to use the restaurant, the parking authority directly profited from the restaurant's operations, and the restaurant alleged that it would lose profits if it ceased discriminating against blacks. Accordingly, the restaurant's racial discrimination was, in these circumstances, an indispensable element in the success of the parking authority. Id. at 724.

All of the same elements appear in this case. The relationship of the prison to the physician providing medical care within the prison parallels the relationship of the parking authority and the restaurant in Burton. As noted in previous sections, North Carolina is required under the Constitution to provide basic medical

care to prisoners.[34] See pp. 24-27, supra. Accordingly, North Carolina gains a direct benefit from the services performed by the physicians. Similarly, the physician gains a direct and substantial financial benefit from the arrangement.

In addition, the benefit to North Carolina is precisely tied to the doctor's actions: the State purports to discharge its undeniable obligation to the prisoners through the services it pays the doctor to deliver. Indeed, there is even a closer relationship between the two cases. In Burton, the authority allegedly profited by the restaurant's racial discrimination, which the authority could not have undertaken directly on behalf of the State. In this case, if there is no state action in deliberately indifferent actions by

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[34] In one respect, this case presents stronger grounds for finding state action than Burton. This case, unlike Burton, also involves a traditional public function.

physicians, the State will have a financial interest in the deliberate under-provision of medical services. See the discussion of the State of Maryland's decision to contract out medical care in its system, supra, pp. 13-16.

It should be particularly noted that neither Burton nor a reversal in this case requires the Court to find state action in activities less closely related to the essential state function. For example, neither Burton nor a reversal in this case would require the federal courts to find state action implicated in the employment relationships existing among private contractors. Employment decisions are not directly related to the State's interest in discharging the public function of providing basic medical care for prisoners. Nor do they have any relationship to concerns that the handing over of traditionally public functions to private hands is simply

a subterfuge to allow the State to violate the Constitution.

A decision finding state action here would not disturb the holding in Rendell-Baker v. Kohn, 457 U.S. 830 (1982). In Rendell-Baker, this Court refused to find state action in the discharge of teachers at a privately operated high school, although almost all of the students at the school had their tuition paid by the State. The Court noted that while the school was generally the subject of extensive regulation, there was little regulation of personnel functions. Id. at 841. Presumably, the extensive state regulation in Rendell-Baker was directed at those matters with direct impact on the students, since education was the public function involved in the case.

Accordingly, this case is on all fours with Burton because there is a truly symbiotic relationship between the State

and the ostensibly private actor. The activity discharges an obligation of the State for a traditionally exclusively public function, and the challenged action is directly related to the discharge of the public function.

VII. POLICY CONCERNS SUPPORT A FINDING OF STATE ACTION HERE

Presumably, the policy concerns behind the broad refusal of the Court of Appeals to find state action involve a reluctance to subject the actions of medical doctors to federal court review. Such a concern would be appropriate if a finding of state action would convert malpractice actions into constitutional torts. But Estelle v. Gamble, supra, already disposes of this concern with its holding that the proper standard is one of deliberate indifference; mere negligence or malpractice will not

suffice.[35] Accordingly, the policy concerns that apparently led the Court of Appeals to place physicians' actions beyond the reach of the Constitution are better addressed by the substantive rule of liability developed by this Court.

The decision of the Court of Appeals is particularly dangerous because a failure to find state action in a physician's actions would mean that injunctive actions, as well as damages actions, would be barred. Affirming the Fourth Circuit's decision on this basis would radically alter existing law by removing almost the entire subject of prison health care from federal court jurisdiction.[36]

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[35] Deliberate indifference damages claims cognizable in federal court might also state malpractice claims in state court. This partial overlap of claims does not offend the Constitution. Cf. Monroe v. Pape, 365 U.S. 167 (1961).

[36] It is true that administrative officials would still be subject to injunctive orders. But such orders would necessarily be ineffective as to many

To the extent that the decision of the Court of Appeals, like its earlier decision in Calvert v. Sharp, may be limited to contract physicians, there are substantial policy reasons for this Court to reject this line-drawing. For the reasons given earlier in this brief, it is absolutely critical that federal courts continue to assure that the State's duty to provide basic medical care to prisoners is enforced. If States can avoid this duty by contracting out medical services, States will have an obvious incentive to do so, with possibly disastrous results for prison health care. Certainly the Maryland experience demonstrates the reality of this threat. See pp. 13-16, supra.

Except to assure that the State's

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critical aspects of medical care carried out directly by physicians and other health care providers. Moreover, such orders potentially could cause problems by requiring custody officials to supervise the delivery of medical care by physicians.

constitutional duties are respected, this Court has no interest in affecting whether States provide medical care through state employees or contract out such care. A decision finding state action in the type of medical care provided by Dr. Atkins will be such a neutral decision, because a desire to avoid constitutional requirements cannot affect a decision on how to provide medical services.[37]

At the same time, such a decision will not discourage contracting out medical services when otherwise in the State's interest. The State can indemnify contract practitioners for constitutional liabili-

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[37] This approach would be consistent with City of Revere v. Massachusetts General Hospital, supra, in which the Court held that although there was a constitutional duty to provide medical care to jail inmates, the Constitution does not dictate how the cost of that care should be allocated between the jail and the provider of the medical care.

ty,[38] and it can also provide for representation for medical providers in federal court. Indeed, North Carolina has already provided such legal representation to contract care providers. This is why, ironically enough, it is the North Carolina Attorney General Office that argues before this Court that Dr. Atkins' action on behalf of the State did not constitute state action.[39] Because a decision finding state action will not discourage contractual medical relationships, except contractual medical arrangements solely designed to avoid constitutional mandates, this Court should not hesitate to find state action in this case.

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38 As noted supra, pursuant to Estelle v. Gamble, supra, the scope of liability under the Constitution does not include malpractice actions.

39 See N.C.Gen.Stat. 143.300.7.

CONCLUSION

The decision of the Court of Appeals, in its broad reading, is a truly radical one that, if affirmed, would dramatically alter the current understanding of the state action doctrine. Because it would deprive federal courts of jurisdiction over virtually all aspects of prison health care to prisoners, it would undo much of the progress made in providing minimally adequate health care in the nation's prisons. Once again, there would be an iron curtain between prisoners and the courts with respect to basic human needs. Even a narrow affirmance of the decision of the Court of Appeals would jeopardize progress and create a pressure for the privatization of prison medical care for illegitimate reasons. For these reasons, the amici urge this Court to reverse the decision of the Court of Appeals.

Respectfully submitted,

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APPENDIX I

> [O]ne inmate received a blow in the eye during a basketball game on April 28, 1978. Although he complained constantly, he was put off for one pretext or another until he was finally seen at Wishard Hospital on May 30, 1978, and a detached retina was found. He was operated on June 2, which was three weeks too late to save the eye. Another, who was taking penicillin for rheumatic heart disease when he entered the Reformatory, did not receive another prescription for 18 months. Another sought help for well over a year for a cough, severe chest pains, and difficulty in breathing. He received no help except cold medicine and cough drops from the medical technicians. He was finally referred to Wishard, where an operation disclosed a mass the size of a baseball in his right lung. Others have gone for months without detection of communicable tuberculosis.

French v. Owens, 538 F.Supp. 910, 918 (S.D.Ind. 1982), aff'd, 777 F.2d 1250 (7th Cir. 1985).

> Mr. Stubblefield first came to the prison infirmary at 3:00 PM on February 9, 1979, and complained of chest pains. His blood pressure and pulse were checked and he was sent back to

his cell. By 6:00 PM, Mr. Stubblefield returned to the infirmary again complaining of chest pain. He appeared to be in "severe distress" and had trouble breathing. PX 88. Nevertheless, no physician came to check on Stubblefield. A prison doctor was called by telephone and he prescribed a mild tranquilizer. Stubblefield was then admitted to the prison infirmary. By 7:30 PM, Stubblefield's blood pressure had dropped to 60/40 and his pulse was irregular. Plaintiffs' medical expert and defendants' medical expert agreed that Stubblefield "had suffered some type of cardiovascular catastrophe at that point." "He was in cardiovascular shock." Tr. at 2120, 2121. Still no doctor came to see Stubblefield. At 9:45 PM, Stubblefield's blood pressure was still only 60/40 and his pulse rate was up to 120 beats per minute. The infirmary progress notes state, "request [the doctor] to come in again and again he declined." PX 88. Finally, after four attempts to get [the doctor] to see Stubblefield, the infirmary called a second prison doctor. This doctor prescribed some medication for Stubblefield, though he did not order that Stubblefield be sent to the hospital until midnight, nine hours after Stubblefield had begun alerting the prison personnel to his chest pain... He died the following day.

Wellman v. Faulkner, 715 F.2d 269, 273-274

(7th Cir. 1983), cert. denied, 468 U.S. 1217 (1984).

> One inmate, in otherwise excellent condition, suffered an appendicitis. After misdiagnosis and hours of delay before receiving competent attention, he was then delayed without any excuse at all, from being transported to the Colorado State Hospital. Transport was further interrupted and, upon arrival, adequate attention was not given until after the appendix ruptured and the inmate was placed in a life-threatening situation. The inmate was then transferred back to Old Max before he had adequately recovered and complications and further needless suffering ensued. Follow-up care was delayed and incompetent. Were it not for the fact that the inmate was previously in superb condition because of his training as a champion weightlifter, he might have died.
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> * * *
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> Another inmate came to the institution with a serious heart condition. Instead of being placed in the infirmary for direct observation and monitoring of his condition, he was placed in one of the cellhouses. He died before receiving medical attention.

Ramos v. Lamm, 485 F.Supp. 122, 143 (D.Col. 1979), aff'd in pert. part, 639 F.2d 559 (10th Cir. 1980), cert. denied, 450 U.S.

104 (1981).

> Testimony has shown that inmate nurses often perform x-ray photography, conduct and interpret eye examinations, administer oral anesthesia, lance boils, and insert sutures. A few inmate nurses have regularly engaged in setting and casting broken bones, and one sutured heel tendons and performed a finger-tip amputation.
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> Inmate nurses have also been instructed or permitted to make entries in their patients' charts. Deliberate falsifications in the charts are often made by these inmates; e.g., patients' liquid inputs and outputs have been improperly charted; spurious temperature readings have been inserted; and fictitious administrations of medication have been shown (some entries having been registered up to twenty-four hours before the medicines were supposedly dispensed).

* * *

While inmate nurses all too often improperly undertake treatment functions for which they are unqualified, the record reveals the irony that they have been reluctant to perform certain basic custodial duties. Grievous neglect of the personal care of patients at the HUH has resulted. Examples are numerous: on many occasions, routine preoperative

> enemas and urine bags were allowed to overflow (particularly on Monday morning, when no RN had been in the hospital all weekend); urine collections for urinalyses were either not accomplished or the specimens were not refrigerated, thus making them useless; intravenous solutions were allowed to run dry; bandages were not changed on time; incontinent inmates were allowed to lie in their own feces or urine for long periods; and inadequate hygienic care was administered to invalided patients generally. Decubitus ulcers (bedsores) were frequent among bedridden patients, as a result of the inattentive nursing. These open lesions are particularly troublesome at TDC, although they may usually be prevented simply by a systematic regimen of washing and turning the bedfast inmates.

Ruiz v. Estelle, 503 F.Supp. 1265, 1311-1312 (S.D.Tex. 1980), mod. on other grounds, 679 F.2d 1115 (5th Cir. 1982), cert. denied, 460 U.S. 1042 (1983).

> Both Dr. King and plaintiffs' expert, Dr. Whitney Addington, testified to the circumstances surrounding the tragic death of Mr. Willie Graham on June 15, 1975. Prior to commitment to the Department of Corrections, Graham was a chronic asthmatic who generally responded to traditional therapy associated with the treatment of asthma. Such treatment would include the use of bronchodialators; and in

particular, the use of epinephrine, subcutaneously, and aminophylline, intravenously, in the event of acute attack. The use of sedatives is contraindicated in the treatment of acute asthmatic patients and could cause ventilatory failure.

During this brief period of time Mr. Graham suffered recorded asthma attacks on at least fifteen occasions. His "treatment" was devised and carried out, for the most part, by unlicensed, untrained and unsupervised medical technicians and inmates, who without prior consultation with a physician, prescribed and administered a wide variety of medications, which could legally only be prescribed by a physician. Moreover, these medications were, in repeated instances, inappropriate, contraindicated, of insufficient dosage to be effective, in excessive dosages which may have resulted in toxicity; and, in eleven (11) occasions during recorded asthma attacks, aminophylline was given by intramuscular injection, a totally unrecognized, painful method of administration.

On the few instances when Graham was seen by a physician, Dr. Vidal, acceptable care was still not given. Medications that were at odds with acceptable practice were prescribed, necessary laboratory tests were not ordered, and proper documentation of physical findings was not made

in Graham's medical record. In addition, Dr. Vidal failed to terminate the intramuscular injections of aminophylline. Instead he verbally ordered, on June 13, 1975, that intravenous bronchodialators and inhalation therapy, the essential treatment for asthma, be denied and, instead substituted the administration of Sparine. This drug, a tranquillizer used in the treatment of psychosis, is a respiratory depressant which can cause respiratory failure in an asthmatic who is in or going into ventilatory failure.

Therefore, when Mr. Graham suffered an asthma attack on June 14th and June 15th, 1975, he was administered Sparine and use of intravenous bronchodialators were denied. At that point, carbon dioxide was building up and only a mechanical ventilator could save him. Instead, he was transferred to segregation on June 15, 1975, and died within hours in his cell.

* * *

Inmate Chester Graves died at the institution on February 3, 1976. Graves had been returned to the institution after having had a vein ligation. He was admitted to the institutional medical unit by a CMT at about 5:30 P.M. with swelling, shortness of breath, and chest pain. Graves died the following morning and was found to have had a

pulmonary embolism.

Dr. King concluded that in this instance, the CMT was clearly unable to make a simple diagnosis of "classic symptoms" on the night of admission and that a person of appropriate skill would have sent this man immediately to a full-service hospital where he would have received an anti-coagulant. King stated that cases like Graves indicated that high level of skill and judgment is required at Menard during the night-time hours. At the close of trial, there was not even a registered nurse at the institution at night.

Mr. Kenneth Daugherty died at Menard on April 15, 1976. Dr. King, on August 31, 1977, reviewed his medical records at trial concluding that Daugherty's life may have been saved if qualified personnel had been available to interpret an E.K.G. and physical symptoms which clearly suggested the ultimate cause of death. King testified that the records indicated: the delegation of responsibility for medical care to an unlicensed, unqualified person; the lack of an emergency medical system; the lack of procedures for transferring a patient to another facility for proper monitoring of his condition; and lack of medical audit procedures. In this last regard, King stated that the CMT involved in this case should have been reprimanded by his superiors and

that Dr. King would not have retained this CMT in his own system in view of the CMT's conduct in this case.

Inmate Hansen died at the institution on June 22, 1977. This inmate's case was reviewed at trial by Dr. King. The panel had noted in their second report that the defibrillator at the institution was designed for pediatric use and was inadequate for treating a large size adult. King testified that Hansen was a large man of 240 pounds and that the unit at Menard was not able to generate enough power to perform defibrillation on a man of this size. Medical records indicate several unsuccessful attempts to cardiovert the patient with the defibrillator. King stated that an adequate unit might have saved his life.

Lightfoot v. Walker, 486 F.Supp. 504, 519-520 (S.D.Ill. 1980).

APPENDIX II

Amici surveyed the relevant statutes of the fifty states. Only one state by statute allows any prisoner to choose a medical care provider: LOUISIANA- La.Rev.Stat.Ann. §15:860 (West 1981). Most departments of corrections assume the responsibility for medical care of all prisoners: ALABAMA - Ala. Code §§ 14-1-8, 14-1-12 (1975); ALASKA - Alaska Stat. §§ 33.30.011, 33.30.100, 33.30.121 (1986); ARIZONA - Ariz.Rev.Stat.Ann. §§ 31-201.01, 41-1604, 41-1604.01 (1985); ARKANSAS- Ark.Stat.Ann. §46-150 (1977); CALIFORNIA- Cal. Penal Code §§ 6125 et seq., (Deering 1982); COLORADO - Col.Rev.Stat. §§ 23-21-110, 17-1-103 (1986); CONNECTICUT- Conn.Gen.Stat.Ann. §§ 18-81, 18-1019 (West 1975); DELAWARE - Del. Code Ann.tit.11, §6536 (1979); FLORIDA - Fla.Stat.Ann. §§ 945.12, 945.601, 945.603 945.6035 (West 1987); GEORGIA - Ga. Code Ann. §42-5-2 (1985); HAWAII - Hawaii Rev.Stat. §§ 353-6, 353-10 (1976); IDAHO - Idaho Code §§ 20-209, 20-501 (1979); ILLINOIS- Ill.Rev.Stat.Ch. 38, §§ 1003-6-2, 1003-7-2, 1003-8-2, 1003-11-1, 1003-13-2 (1982); INDIANA - Ind. Code Ann. §§ 11-10-3-2, 11-10-3-4 (West 1981); IOWA - Iowa Code §217A.2 (1987); KANSAS - Kan.Stat.Ann. §§ 75-5209, 75-5210 (1977); KENTUCKY- Ky.Rev.Stat.Ann. §§ 196.030, 197.020, 211.920, 211.925, 439.600 (Bobbs-Merrill 1985); LOUISIANA - La.Rev.Stat.Ann. §§ 15:827, 15:831, 15:833, 15:860 (West 1981); MAINE - Me.Rev.Stat.Ann.tit.34, §§ 7, 134, 631; tit.34-A, §§ 3031, 3235 (1978); MARYLAND - Md.Ann. Code art.27, §698 (1982); MASSACHUSETTS - Mass.Gen. Laws Ann.Ch.27 §2; Ch.125 §18; Ch.127 §§ 16, 39,

90A, 117, 117A, 118 (West 1984); MICHIGAN- Mich.Comp. Laws Ann. §§ 791.265, 791.265b (1982); MINNESOTA - Minn.Stat.Ann. §244.07 (West 1987); MISSISSIPPI - Miss. Code Ann. §§ 47-5-112, 47-5-120 (1987); MISSOURI- Mo.Ann.Stat. §§ 217.230, 217.375, 217.420, 217.425 (Vernon 1983); MONTANA - Mont. Code Ann. §53-1-204 (1986); NEBRASKA- Neb.Rev.Stat. §83-181 (1981); NEVADA- Nev.Rev.Stat. §§ 209.331, 209.381, 209.382 (1985); NEW HAMPSHIRE - N.H.Rev.Stat.Ann. §§ 21-H:3, 21-H:13, 623.1 (1986); NEW JERSEY - N.J.Stat.Ann. §§ 30:4-7, 30:4-7.1, 30:4-7.2, 30:4-7.3, 30:4-91.3 (West 1981); NEW MEXICO - N.M.Stat.Ann. §§ 33-2-13, 33-2-16 (1986); NEW YORK - N.Y. Correction Law §§ 23, 47, 141, 851, 852 (McKinney 1987); NORTH CAROLINA -N.C.Gen.Stat. §§ 148-4, 148-19, 148-22.2, 148-46.2 (1983); NORTH DAKOTA - N.D.Cent. Code §§ 12-47-27, 23-07-08 (1985); OHIO - Ohio Rev. Code Ann. §§ 5120.16, 5145.23 (Baldwin 1981); OKLAHOMA- Okla.Stat.Ann.tit.43A §701; tit.57 §§ 38, 57, 224, 530 (West 1987); OREGON- Or.Rev.Stat.Ann. §§ 179.360, 179.479, 179.490 (1985); PENNSYLVANIA - 37 Pa.Admin. Code §93.12 (Shepard's 1987); RHODE ISLAND- R.I.Gen. Laws §§ 40-2-12, 40-2-14, 40.1-2-16, 40.1-2-19, 42-56-1, 42-56-3, 42-56-10, 42-56-16, 42-56-18, 42-56-20 (1977); SOUTH CAROLINA - S.C. Code Ann. §§ 24-1-130, 24-3-160, 24-3-210 (Law Co-op. 1986); SOUTH DAKOTA - S.D. Codified Laws Ann. §24-2-4 (1979); TENNESSEE - Tenn. Code Ann. §§ 4-6-109, 41-21-203, 41-21-204 (1979); TEXAS - Tex.Rev.Civ.Stat.Ann.arts. 6166g, 6203c; UTAH - Utah Code Ann. §§ 64-13-25, 64-13-26, 64-13-34, 77-34-1, 77-34-2, 77-34-3 (1986); VERMONT- Vt.Stat.Ann.tit.3, §262; tit.28, §§ 801, 808 (West 1986); VIRGINIA - Va. Code §§ 53.1-32, 53.1-33, 53.1-34 (1982); WASHINGTON - Wash.Rev. Code Ann. §§ 72.09.040, 72.09.050, 72.13.080, 72.66.018

(1982); WEST VIRGINIA - W.Va. Code §25-1-16 (1986); WISCONSIN - Wis.Stat.Ann. §53.10 (West 1957). Only one state code does not mention any specific responsibility for the medical care of prisoners: WYOMING - Wyo.Stat.Ann. (1986).